

Health Insurance Exchanges Summary of Stakeholder Comments

| Questions | Comments |
|--|---|
| 1. Should Maine operate its own exchange or opt to let federal government administer? What are the benefits of operating the exchange? Are there any disadvantages? | <ul style="list-style-type: none"> ■ Maine should operate own exchange ■ Able to design exchange best to meet needs of population and insurance market ■ More flexible and accountable ■ Will require commitment of resources |
| 2. How should an exchange be organized and governed? Should there be a separate exchange for individuals and one for small businesses? Should Maine consider forming an exchange with another state or states? Should the exchange be housed in a government agency, a nonprofit organization or another entity? | <ul style="list-style-type: none"> ■ Exchange must be transparent to public—needs government oversight ■ Governance must include stakeholders; different opinions on insurer and provider representation ■ Need strong conflict of interest rules ■ No multi-state exchange, but explore consolidation of “back-office” functions with other New England states ■ Offer different functions for individuals and small businesses administered through single exchange ■ Broad funding sources needed to sustain exchange operations |
| 3. What rating rules should be in place for carriers offering individual and small group plans in an exchange? Should the same rules apply to plans offered within an exchange and outside an exchange? Should the same rating rules apply to individual and small group plans within an exchange? | <ul style="list-style-type: none"> ■ Same rating and other rules should apply to plans in and out of exchange ■ Consider changing community rating bands to conform to federal law (3 to 1) ■ Consider uniform rules for both individual and small group plans ■ Consider merging markets although past studies have not supported merger because of premium impact ■ Phase-in exchange for small businesses with enrollment of groups 1-50 initially |
| 4. What are the risks of adverse selection within an exchange? How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums? Are there different considerations relating to adverse selection for individual or small group plans? | <ul style="list-style-type: none"> ■ Minimize adverse selection by requiring same rules in and out of exchange ■ Consider changing community rating bands to conform to federal law (3 to 1) ■ Offer an HSA (health savings account) plan within exchange to small businesses |

**Joint Select Committee on Health Care Reform
Opportunities and Implementation
October 1st Meeting**

**Health Insurance Exchanges
Summary of Stakeholder Comments**

| Questions | Comments |
|---|---|
| <p>5. The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers---bronze, silver, gold and platinum---and a catastrophic plan for those under age 30 or who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision? Should an exchange have a role in standardizing plans and defining benefits and cost sharing?</p> | <ul style="list-style-type: none"> ■ Plans must be easily compared by consumers in and out of exchange ■ Plans must be affordable ■ Exchange should have role in standardizing plans ■ Plans offered in exchange should have same benefits as required under federal law and not go beyond those benefit requirements ■ Exchange should promote high-value plans |
| <p>6. Should the exchange have a role in selecting carriers to participate in an exchange? What criteria for participation should be included? How many carriers should participate? Or should all carriers be required to participate in an exchange?</p> | <ul style="list-style-type: none"> ■ Mixed response ■ Carriers suggest exchange participation be voluntary but open to all carriers meeting requirements ■ Other stakeholders suggested exchange should be active in negotiating participation of carriers to reduce costs and improve quality ■ Prohibit carriers from selling different plans outside of exchange |
| <p>7. How should an exchange be designed to be user-friendly to both individuals and small businesses? Should a website be the primary entry point to an exchange? How can an exchange be designed to provide access for individuals to other publicly-funded health plans? What other types of outreach and education are needed? What is the role of the Navigator program? What is the role of insurance agents?</p> | <ul style="list-style-type: none"> ■ Critical that exchange be user-friendly for both consumers and small businesses ■ One-stop shopping, yet carriers suggest that enrollment and other administrative functions should be handled by individual carriers ■ Website is important, but toll-free telephone access and local access to education and assistance is needed ■ “Navigators” should be licensed and regulated ■ Insurance agents/brokers must have continued role especially with small businesses ■ Coverage transitions must be seamless to consumers and small businesses ■ Consider Basic Health Plan options to alleviate administrative burden and make coverage easier to access for those with incomes between 133% and 200% of federal poverty level |



Consumers for AFFORDABLE Health Care

Advocating the right to quality, affordable
health care for every man, woman and child

12 Church Street
Post Office Box 2490
Augusta, ME 04338-2490

Telephone: 207-622-7083
Fax: 1-888-214-5233

Website: www.maine cahc.org
Email: consumerhealth@maine cahc.org

To: Sen. Joseph Brannigan, Chairman, Rep. Sharon Treat, Chairwoman, and Members of the Joint Select Committee on Health Reform

Cc: Colleen McCarthy-Reid, OPLA

Fr: Joseph P. Ditré, Esq., Exec. Dir.

Re: Responses to Questions Posed to Consumers regarding Exchanges

Da: September 30, 2010

Below are additional comments and specific answers to the Committee's questions that time constraints prevented from being presented at the session on September 21, 2010. Thank you for the opportunity to present on behalf of Maine consumers last week.

The PPACA was intended to fix a broken marketplace that leaves 50 million Americans uninsured, millions more "uninsurable" and millions more "underinsured." The PPACA is not intended to replicate the current broken market but to transform it into a functioning market that places the medical needs of Americans over the profits of the insurance industry. From its provisions, it is clear that the intent was to stop the practices that lead to risk selection and risk avoidance and to return fair competition - competition based on price, quality, and service - to the market place. That won't happen if we allow the current financially vested stakeholders to determine the future of the Exchanges.

1. *Should Maine operate its own exchange or opt to let federal government administer?* Maine should operate its own exchange but if resources are restricted should be flexible to permit a federal exchange. *What are the benefits of operating the exchange?* Maine knows its population and insurance market best. Maine can design an exchange that meets local needs. The federal government cannot be as precise in its design because of its need to accommodate multiple diverse state systems. *Are there any disadvantages?* It can be resource intensive. It requires commitment and capacity.

2. *How should an exchange be organized and governed?* Ideally, it should be an independent state agency that is not subject to changes of Administration. *Should there be a separate exchange for individuals and one for small businesses?* No. First, the Exchange needs to build staff and expertise to negotiate rates with insurance companies. It needs to gain efficiencies in operating its front-office and back-office operations. One exchange makes that possible. Second, our population is too small and there is considerable movement in the job market (between self-employed and working for a larger business). This calls for one exchange to understand and meet the needs a changing workforce. *Should Maine consider forming an exchange with another state or states?* No, because it would be difficult to manage if one state adopts a law or laws that other states cannot or do not want to adopt. However, this does not preclude cooperating with other states on "back-office" process and technology. *Should the exchange be housed in a government agency, a nonprofit organization or another entity?* An independent state agency that is not subject to changes in Administrations would be best.

3. *What rating rules should be in place for carriers offering individual and small group plans in an exchange?* Same benefits, same products, same consumer protections, and same rating rules inside as outside. *Should the same rules apply to plans offered within an exchange and outside an exchange?* YES.

Should the same rating rules apply to individual and small group plans within an exchange? YES, they do already. A further step should be taken to merge the individual and group markets. The individual market in ME has shrunk so significantly that the potential cost increase to small groups is very small. There are great efficiencies to be gained by merged markets with respect to rate hearings, rate filings, marketing, lower administrative costs, and in terms of principles for consumer ease of selection - i.e., uniformity, consistency, and simplicity. The bureau of Insurance is currently doing an actuarial study to confirm these assumptions in terms of cost-benefits.

4. *What are the risks of adverse selection within an exchange?* Affordability creates the risk of adverse selection. In other words, if prices charged outside the exchange for less beneficial plans are lower and attract younger or healthier people, then the exchange may rapidly become a "high risk pool" or dumping ground for carriers. That defeats the purpose of an Exchange. We need to learn from the experience of Dirigo - a voluntary program placed in the marketplace which encountered the same challenges that will face the Exchange unless you prevent it. *How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums?* Merging the markets will significantly decrease risk to carriers because the costs will be spread over a larger pool, especially when ME moves to groups of 1 - 100. There are other ways to reduce the impact, but should not be applied until the merged market and increased group size are in place for at least two years and data regarding experience can be examined. *Are there different considerations relating to adverse selection for individual or small group plans?* With merged markets the same considerations will apply to individual and small group plans. The key to avoiding adverse selection within the Exchanges is to regulate what plans can be offered outside the Exchanges. By keeping offerings consistent both inside and outside the Exchanges competition will be on cost and quality, not on being able to attract a lower risk population.

5. *The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers---bronze, silver, gold and platinum---and a catastrophic plan for those under age 30 or who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision?* Remember the goal: make buying insurance as easy as possible for the consumer. Consumer focus groups regarding plans and choices should be conducted. Most consumers and small business owners are overwhelmed with the dizzying array of so-called "choices" designed for that purpose. These "choices" make cost and quality comparisons impossible. Therefore, the product offerings should be limited. The goal is to make purchasing health insurance as easy as possible -- not create barriers. *Should an exchange have a role in standardizing plans and defining benefits and cost sharing?* Yes, the Exchange should work in conjunction with the ME Bureau of Insurance, the DHA, DHHS, Maine's non-profit Consumer Assistance Program, the AG, and other non-financially interested agencies and organizations to accomplish this enormous task in order to make coverage affordable and comprehensive. By defining benefit and cost sharing levels for the five plans, the goal of simplicity will be satisfied. This will enable consumers to make informed decisions based on quality and cost.

6. *Should the exchange have a role in selecting carriers to participate in an exchange?* YES. *What criteria for participation should be included?* If a carrier sells a product or products in any market, i.e., in the Exchange, then it should be required to sell the same products outside the Exchange. Only plans that have been approved for sale within the Exchange should be available outside the Exchange. *How many carriers should participate?* If they all play by the same rules and must compete on the same terms, then as many as are willing. Amy Lischko stated an important point -- MA experience with its Connector (Exchange) was that more of the smaller companies were chosen by consumers buying coverage through

the exchange. In other words, the Exchange had a role in reducing the dominance of larger carriers on the market. This is important if ME's market wants to reduce the anticompetitive impact of the monopoly insurer in our market. *Or should all carriers be required to participate in an exchange?* Same as above. In essence, if a carrier sells in any market, it must sell the same products both inside and outside the Exchange.

7. *How should an exchange be designed to be user-friendly to both individuals and small businesses?*

The Consumer Assistance Program is one key to obtaining consumer feedback and involvement in designing the Exchange and the products and coverage it offers. Creation of the Exchange should also allow enough time for pilot testing of all parts of the process. *Should a website be the primary entry point to an exchange?* Toll free phone lines and the website should be the primary entry points. Many older Mainers do not use the internet. Some rural areas of ME do not have high speed access and therefore cannot get the info they need from a website. Lots of outreach and education and marketing are needed to inform the public about access points and how to find them. In addition to these two primary entry points, it will also be necessary to have "Navigators" who can meet with individuals or small business to explain things (and facilitate enrollment) in person. This might be done with static store front locations or with "enrollment fairs" held in locations throughout the state. *How can an exchange be designed to provide access for individuals to other publicly-funded health plans?* As stated in the law, there must be a single entry point for both full government assistance (Medicaid/MaineCare) and tax subsidies for private insurance. The Exchange must be able to handle enrollment in public assistance plans. *What other types of outreach and education are needed?* The Exchange should work closely with the Consumer Assistance Program to develop consumer focus groups and design products that meet consumer needs. *What is the role of the Navigator program?* The Navigator should not be used to replicate the existing market. Navigators need to go beyond -- way beyond -- the traditional market approach -- i.e., commissions to agents and agent sales/marketing. Navigators need to be trained in all coverage -- public, private, and subsidized including non-Exchange public programs like Medicare and MaineCare. *What is the role of insurance agents?* Agents are helpful but their role needs to be transformed to de-link income from sales of particular products. Agent commissions, if continued, must be disclosed. Agents and navigators need to attend Navigator education, certification, and accountability (i.e., licensing) programs offered by the BOI.

DRAFT NAIC MODEL EXCHANGES

Draft: 9/27/10
A new model

Comments are being requested on this draft on or before Oct. 6, 2010. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

Table of Contents

| | |
|-------------|-----------------------------------|
| Section 1. | Title |
| Section 2. | Purpose and Intent |
| Section 3. | Definitions |
| Section 4. | Establishment of Exchange |
| Section 5. | General Requirements |
| Section 6. | Duties of Exchange |
| Section 7. | Health Benefit Plan Certification |
| Section 8. | Funding; Publication of Costs |
| Section 9. | Regulations |
| Section 10. | Effective Date |

Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

Drafting Note: States expanding the definition of “qualified employer” to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to “small” employers.

Section 3. Definitions

For purposes of this Act:

- A. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- B. “Educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.
- C. “Exchange” means the [insert name of State Exchange] established pursuant to section 4 of this Act.
- D. “Federal Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

- E. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection I, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- F. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

NOTE: The Statutory Language Team recognizes that the definition of "health benefit plan" needs to be revisited to ensure its consistency with definitions used in HIPAA and the Affordable Care Act.

- (2) "Health benefit plan" does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers' compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; or
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- G. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- H. “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
- I. “Medical care” means amounts paid for:
 - (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
 - (3) Insurance covering medical care referred to in paragraphs (1) and (2).
- J. “Qualified employer” means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the Exchange provided that the employer:
 - (1) Has its principal place of business in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed; or
 - (2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection J accordingly.

- K. “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.
- L.
 - (1) “Qualified individual” means an individual who:
 - (a) Is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and
 - (b) Resides in this State.
 - (2) “Qualified individual” does not include an individual:
 - (a) If, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges; or
 - (b) If, the individual is not, or is not reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

- M. “Secretary” means the Secretary of the federal Department of Health and Human Services.
- N. “SHOP Exchange” means the Small Business Health Options Program established under section 6 of this Act.
- O. (1) “Small employer” means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define “small employers” as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

- (a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;
- (b) An employer and any predecessor employer shall be treated as a single employer;
- (c) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
- (d) An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment in qualified health plans available to its employees.

- P. “Small group market” means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

Section 4. Establishment of Exchange

- A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange’s decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States’ personnel and procurement rules. The Exchange could also be located at an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange’s enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange’s Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in

decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange needs to obtain such a license.

B. The Exchange shall:

- (1) Facilitate the purchase and sale of qualified health plans;
- (2) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market in this State; and
- (3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in the individual and small group markets, but a health carrier is not an eligible entity.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act that set out the appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange State shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. The Exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act.

Drafting Note: The Federal Act allows States to require additional benefits, but only if the State defrays the additional costs of premium and cost-sharing assistance to enrollees. States electing this option should modify subsection C accordingly, specifying the additional benefits required and the mechanism for payment to or on behalf of the enrollees.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. Optional clauses are provided at the end of this section to facilitate uniformity among those States that elect to use their Exchanges to address certain widely shared concerns.

The Exchange shall:

- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;
- B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- C. Provide for enrollment periods, as determined by the Secretary under section 1311(c)(6) of the Federal Act;
- D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act;
- F. Utilize a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;
- G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;
- H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;
- I. Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for the individual market, but only if the Exchange has adequate resources to assist these individuals and employers.

- J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:
 - (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
 - (2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- K. Transfer to the federal Secretary of the Treasury the following:

- (1) A list of the individuals who are issued a certification under subsection I, including the name and taxpayer identification number of each individual;
 - (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:
 - (a) The employer did not provide minimum essential health benefits coverage; or
 - (b) The employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
 - (3) The name and taxpayer identification number of:
 - (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
 - (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;
- L. Provide to each employer the name of each employee of the employer described in subsection K(3)(b) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
- M. Perform duties required of, or delegated to, the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;
- N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act and award grants to enable Navigators to:
- (1) Conduct public education activities to raise awareness of the availability of qualified health plans;
 - (2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;
 - (3) Facilitate enrollment in qualified health plans;
 - (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and
 - (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;
- O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers; and
- P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer; and
- Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including:
- (1) Educated health care consumers who are enrollees in qualified health plans;

- (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
- (3) Representatives of small businesses and self-employed individuals;
- (4) The [insert name of State Medicaid office]; and
- (5) Advocates for enrolling hard to reach populations.

[R. et seq.: Optional clauses specifying additional duties of the Exchange. The Exchanges (B) Subgroup Statutory Language Team preparing this initial exposure draft recommends that these clauses be developed with input from regulators and interested parties, and welcomes your suggested language.]

Drafting Note: States should be aware of the interplay between the duties established for the Exchange under this Act and ERISA's fiduciary duties.

Section 7. Health Benefit Plan Certification

- A. The Exchange may certify a health benefit plan as a qualified health plan if:
 - (1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act;
 - (2) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;
 - (3) The health carrier offering the plan:
 - (a) Is licensed and in good standing to offer health insurance coverage in this State;
 - (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level in the Exchange;
 - (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer; and
 - (d) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish.
 - (4) The plan meets the requirements of certification as promulgated by regulation by the Secretary under section 1311(c)(1) of the Federal Act and by the Exchange pursuant to section 9 of this Act; and
 - (5) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Drafting Note: States should consider whether the Exchange should delegate this function to the commissioner.

- B. The Exchange shall not exclude a health benefit plan:
 - (1) On the basis that the plan is a fee-for-service plan;
 - (2) Through the imposition of premium price controls; or
 - (3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.
- C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

- (1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

- (2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:
 - (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
 - (viii) Information on enrollee and participant rights under title I of the Federal Act; and
 - (ix) Other information as determined appropriate by the Secretary; and
- (b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and
- (3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

Section 8. Funding; Publication of Costs

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.
- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under title I, subtitle D of the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Effective Date

This Act shall be effective [insert date].

W:\Health Care Reform\Exchanges\Health Benefit Exchanges.doc



To: The Honorable Joseph C. Brannigan, Senate Chair
The Honorable Sharon Anglin Treat, House Chair
Joint Select Committee on Health Care Reform Opportunities and
Implementation

Date: October 1, 2010

Thank you for the opportunity to share with you our comments regarding the structure and operation of a health insurance exchange in Maine. We are pleased to submit the following comments and would be happy to answer any questions you might have.

1. Should Maine operate its own exchange or opt to let federal government administer? What are the benefits of operating the exchange? Are there any disadvantages?

Anthem believes that Maine should design and operate its own exchange so that it best meets the needs of its own unique marketplace. In creating its own exchange, Maine will be able to take advantage of state flexibility provided under federal law to thoughtfully create an exchange that will work with the needs of its individuals and small businesses and which it can adapt as market conditions in the state change. A competitive exchange that works in tandem with appropriate state agencies will facilitate access and promote plan choice, thereby helping individuals and small employers to find a plan that meets their health care needs. To that end, Maine should consider designing a "facilitator" exchange that will build upon existing state and federal law and mitigate the risk of creating administrative burden, higher costs and less choice for consumers that could result from other types of exchange models or execution. This is especially important given the many new regulatory elements of the Affordable Care Act (ACA), including several new consumer protections that exchanges will not need or want to duplicate.

2. How should an exchange be organized and governed? Should there be a separate exchange for individuals and one for small businesses? Should Maine

consider forming an exchange with another state or states? Should the exchange be housed in a government agency, a nonprofit organization or another entity?

Maine should design a "facilitator" exchange that will build upon existing state and federal law without establishing additional regulatory rules, especially since the ACA already protects consumers in many new ways.

Anthem believes that regardless of the governance structure, any state-based exchange should leverage existing state capabilities and efficiencies and include formal, ongoing consultation with key stakeholders relevant to carrying out the activities the exchange is required to conduct under federal law so that the exchange runs efficiently and is able to fulfill its key duties. Such stakeholders should include, at minimum, the following:

- Consumers;
- Health plan enrollment experts;
- Bureau of Insurance representative(s);
- State Medicaid office representative(s);
- Consumer advocates who can assist in involving hard-to-reach populations;
- Providers;
- Small business owners and self-employed persons; and
- Health insurers and HMOs marketing within the state.

Further, Anthem believes that it is imperative that the exchange have reporting and fiduciary accountability to appropriate state authorities, such as the Bureau of Insurance, state legislature or Governor's Office.

There must also be requirements that the governing body's work be done in a transparent way and that there be a formal redress process in case issues should arise. In no circumstance should the governing entity of the exchange be an elected position, and, in fact, any exchange should be free from overt political influence concerning the plan choices available to individuals or small employers.

The exchange should develop governing documents that explicitly incorporate ethics standards, accountability to members, freedom from conflict of interest and political interests, transparency requirements and fiduciary standards.

Additionally, Maine should consider broad-based funding for the exchange so that the exchange is financially sustainable.

Anthem believes it is important for states to maintain separate and distinct markets for individual and small groups, regardless of whether or not a state decides to consolidate exchanges administratively to gain efficiencies. These separate markets would include separate risk pools, as combining risk pools for the individual and small group markets

is likely to lead to higher rates for small groups due to issues related to adverse selection.

Maintaining separate markets will also allow health insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers. Additionally, Anthem feels strongly that states should permit plans to decide whether or not to sell coverage to either or both of the markets – inside or outside of the exchange. Carrier choice in this regard will increase plan participation, encouraging competition and resulting in higher quality plans. Further, health plans should be able to continue to offer different products to the different markets.

Maine should not consider developing or joining a multi-state or regional exchange due to difficulties related to governing laws, enforcing consumer protections, and regulator jurisdiction. Achieving affordable, quality health care requires adequate rules to protect consumers and maintain confidence in the private health insurance market's ability to drive additional value and affordability—rules which multi-state exchanges put at risk. Anthem embraces a competitive insurance environment; however, all competitors offering coverage to a given individual must be subject to the same rules and regulations. If Maine does form a multi-state exchange in an effort to lower administrative costs, it should ensure that state insurance markets remain separate and distinct.

3. What rating rules should be in place for carriers offering individual and small group plans in an exchange? Should the same rules apply to plans offered within an exchange and outside an exchange? Should the same rating rules apply to individual and small group plans within an exchange?

Exchanges should not establish any unique rules for carriers offering individual and/or small group plans in an exchange outside of those prescribed by state or federal law. Further, for a number of reasons the same rules should apply to plans offered within and outside of an exchange.

- The ACA requires the same rates inside and outside the exchange, which necessitates that the rules be the same inside and outside of the exchange;
- Without the same rules, some selection risk will surface and will impact premiums in both markets; and
- Not having the same rules will add administrative complexity and cost, and will work against the goal of greater affordability.

With respect to rating, the Bureau of Insurance should retain all authority related to health plan pricing for all health plans, including those offered via a state health insurance exchange—authority it was designed to hold and entrusted with by the state. This authority should not be transferred to an exchange.

- As such, state health insurance exchanges should require health plans seeking certification as qualified health plans (QHPs) to submit a justification prior to implementation of the increase in a manner that is consistent with requirements of the Bureau of Insurance.
- Similarly, the exchange should not impose any additional requirements (other than those already required by state or federal law) on QHPs to support premium increases.
- Since the prices must be the same inside and outside the exchange, it is critical that the Bureau of Insurance, as the entity responsible for ensuring insurer solvency, have the purview for reviewing pricing inside and outside of the exchange—and the rules for pricing products inside and outside of the exchange should be the same.

Lastly, given Maine's current rating rules (which are more restrictive than those set forth under federal law), Maine should adopt the federal rating requirements for individual and small group – both inside and outside of the exchange. This would help mitigate any risk of adverse selection and help the exchange to work more effectively and increase coverage rates.

4. What are the risks of adverse selection within an exchange? How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums? Are there different considerations relating to adverse selection for individual or small group plans?

While it is likely that members will change carriers within an exchange at a rate higher than they would outside an exchange, the new federal law includes several mechanisms to help mitigate adverse selection, including transitional reinsurance and transitional risk corridor programs, in addition to a long-term risk adjustment program. Retrospective risk adjustment could help some carriers in mitigating the impact of such changes on premiums, as it is more accurate than a prospective risk adjustment model, particularly in the higher risk portion of the risk curve. Retrospective risk adjustment also does not necessitate the need to track a member from plan to plan. Tracking members as they transition between health plans would demand the creation of unique member IDs that must be utilized by all health plans and new tracking systems that would only serve to increase administrative costs, while yielding less accurate results than a retrospective model. Further, any risk adjustment should be made on the basis of diagnoses, not claim amounts. This would ensure a level-playing field among health plans with different provider network discounts or provider-owned plan structures.

It is also important to note that while the new federal law introduces several new programs to help mitigate selection risk, these programs will result in some additional administrative reporting as well as assessments on insurers that should be evaluated against the benefits of the programs to ensure that value is created.

Outside of these programs, the state can also help mitigate the risks of selection by ensuring that a level playing field exists between health plans by, for example, ensuring that there are no exemptions from any certification or rating standards for any plan and adopting effective open enrollment period policies. Further, since selection is also introduced by having different rules inside and outside the exchange, it is important to consider the non-exchange rules (and their consistency with exchange rules) when trying to limit selection risks in the exchange.

5. The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers---bronze, silver, gold and platinum---and a catastrophic plan for those under age 30 or who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision? Should an exchange have a role in standardizing plans and defining benefits and cost sharing?

In order to maximize consumer choice, competition and health plan participation, Anthem believes that health plans participating in the exchange should only be required to offer one gold and one silver product in the exchange as is required by federal law. While outside of the exchange plans must still meet the requirements of the ACA, they should otherwise be able to offer any combination of metallic plans that they choose, or not offer coverage outside of the exchange at all.

The exchange should not seek to design benefits or approve products, which would result in duplicity and an added layer of expenses for state residents. The ACA already establishes benefit tiers and "essential health benefits" for the individual and small employer markets whether coverage is purchased inside or outside of the exchange that will help consumers to be able to compare the value of different benefit designs. Any standardization of plans or benefits will only serve to limit consumer choice, making it more difficult for consumers to find insurance coverage that meets their needs and budgets. Additionally, such standardization will only serve to limit innovation in insurance product design.

6. Should the exchange have a role in selecting carriers to participate in an exchange? What criteria for participation should be included? How many carriers should participate? Or should all carriers be required to participate in an exchange?

Maine should establish a "facilitator" exchange and not engage in a bidding process or selective contracting, which will limit the number of plans available to individuals and

small employers and thereby undermine the incentive for plans to develop exchange offerings. Ultimately, many individuals and small employers might not find a plan that is right for them in the exchange, which could drive them out of the exchange, or to not enroll in coverage at all.

Anthem believes that Maine should develop an exchange that promotes competition. In order to maximize choice, competition and health plan participation, and minimize regulatory duplication and confusion and market disruption, all carriers with plans that meet the QHP standards required by the ACA and later promulgated by the US DHHS Secretary should be permitted to offer such plans in an exchange. Maine should not impose any additional requirements on QHPs within the exchange beyond those required by the ACA. Should Maine adopt additional certification standards, it should use existing nationally accepted accreditation programs, such as NCQA or URAC, as a proxy for certification.

Any requirements Maine might impose on QHPs participating in the exchange should ensure a level playing field between health plans participating in the exchange. As such, there should be no exemptions from certification standards for any particular type of plan – whether traditional health insurers, Medicaid plans, provider-sponsored plans, or Consumer Operated and Oriented Plans (CO-OPs).

7. How should an exchange be designed to be user-friendly to both individuals and small businesses? Should a website be the primary entry point to an exchange? How can an exchange be designed to provide access for individuals to other publicly-funded health plans? What other types of outreach and education are needed? What is the role of the Navigator program? What is the role of insurance agents?

In order to be user-friendly to both individuals and small businesses, an exchange must be able to provide information about carriers and plans to consumers in a way that is easily understood by consumers. A website is likely to be the most effective primary entry to an exchange; however, it is critical that independent, live assistance be available to those who need it when researching health plan options and completing applications for coverage. A website supported by individuals offering live, real-time assistance could also be designed in such a way to screen applicants for eligibility for public programs

Brokers should be encouraged to participate in the exchange and work in concert with Navigators. Anthem believes that brokers should continue to play a key role in the sale of health insurance inside and outside of an exchange. This is especially true for the small group market, in which brokers often help small businesses with more than the simple election of a health insurance plan. In order to make the exchange a viable marketplace, brokers must not have any incentives to channel business solely inside or

outside of the exchange. To that end, Maine should allow health plans to continue to set broker commissions for sales outside of an exchange and also for coverage sold through an exchange. Brokers should complement the role of Navigators, who must be impartial (with respect to health plans, providers, etc.) and whose role should be limited to the requirements set forth under the ACA.

Additionally, small employers participating in the exchange should be permitted to select specific health plans and carriers for their employees as is permitted by the ACA. Taking this approach will minimize disruption in the small group market and ease the transition to the exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through the exchange.